TABLE I. Interval Hazard Rates for Relapse or Death in First Remission*

Cytogenetic abnormalities	Time from achieving a complete remission (months)			
	0–6	6–12	12–18	18–24
inv16, t(15;17), t(8;21)	0.07 (61)	0.16 (57)	0.16 (47)	0.03 (35)
Diploid	0.19 (53)	0.21 (43)	0.21 (34)	0.13 (23)
+8, −5, −7, abnormal 11q	0.45 (33)	0.39 (18)	0.09 (11)	0.09 (9)
Other	0.26 (19)	0.46 (14)	0.46 (5)	0.33 (3)
All patients	0.21 (177)[a]	0.23 (141)	0.23 (104)	0.10 (75)

*Numbers in parentheses = number of patients entering the 6-month interval.
[a]Eleven patients had insufficient metaphases for cytogenetic categorization.

while those with "poor prognosis" karyotypes have a median survival of 6–10 months.

Once a patient with AML has achieved a first remission, it may require 2–6 months to identify a donor, obtain financial clearance, get the patient to a transplant center, and complete the pretransplant evaluation. This delay may allow for selection of patients who by virtue of having remained in remission are theoretically more likely to have achieved long-term disease control with conventional chemotherapy alone and may not need to undergo transplantation. Such a selection would also bias the transplant outcome over that for conventional chemotherapy. To address this question, we have assessed the relapse rates at 6-month intervals for patients with AML in first remission after conventional chemotherapy.

From January 1, 1990 to July 1, 1994, 230 adults age 17–55 years of age with newly diagnosed AML received induction chemotherapy [4]. Of these, 177 patients achieved a complete remission (CR) and were followed prospectively without transplantation. With a median follow-up of 32 months, 20% relapsed or died in CR within 6 months of remission, 26% in CR at 6 months relapsed or died in CR at 6–12 months after remission, and 29% in CR at 12 months have subsequently relapsed or died more than 12 months after remission. Hazard rates for treatment failure (relapse or death in remission) for patients in various cytogenetic subgroups calculated according to Simes and Zelen [5] are shown in Table I.

Patients with "good prognosis" cytogenetics and those with a normal karyotype had a relatively constant but low risk of treatment failure through the first 24 months after CR. Within the limits of the small numbers, for patients with "poor prognosis" cytogenetics, the risk of relapse or death in CR was not decreased at 6–12 months after CR in comparison to that for less than 6 months after CR. There were too few patients with more than 12 months of follow-up to determine accurately the hazard of late treatment failure, but it appeared to be low. Patients with "other" karyotypic abnormalities had a constant and moderate risk of treatment failure, but the group was too small and heterogeneous to provide reliable conclusions for individual karyotypic abnormalities.

A number of factors have been cited as contributing to a supposedly inflated survival rate after allogeneic marrow transplantation for AML in first remission [6]. Our findings demonstrate that for patients with AML in first remission with "poor prognosis" cytogenetics, continued remission for 2–6 months after conventional chemotherapy does not support the suggestion that they have a reduced rate of relapse. Even if delayed for 6 months, allogeneic transplantation should still be considered an appropriate treatment option for patients with AML in first remission who have "poor prognosis" karyotypes.

Donna Przepiorka
Elihu Estey

Department of Hematology, University of Texas M.D. Anderson Cancer Center, Houston, Texas

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Childbearing Age Patients With Essential Thrombocythemia: Should They Be Placed on Interferon?

To the Editor: Essential thrombocythemia (ET) is a myeloproliferative disorder of increasing frequency in young adults, since automated blood cell counters have been introduced. Optimal prevention and management of thrombotic and hemorrhagic ET complications in patients under 40 years of age is still a controversial issue [1], especially important in young women willing to be protected from the infertility and teratogenicity that may be caused by conventional myelosuppressive therapy [2]. Although normal pregnancies have been reported in several untreated ET patients, there are investigators who report a significantly higher rate of fetal morbidity and mortality due to placental infarctions during pregnancy in ET [2].

The best treatment of ET during pregnancy has not been establilshed yet: aspirin might have a role but carries an increased hemorrhagic risk, platelet-apheresis is of limited efficacy and anagrelide is a drug not released yet for general use. There are recent reports of normal and successful pregnancies in women with hematologic disorders, including ET-treated and controlled with interferon-α (IFN-α) [3–5], suggesting that this drug might be a therapeutic option, although there are no conclusive data about the metabolism and possible side effects of IFN-α during pregnancy.

We report a 31-year-old woman diagnosed of ET for 6 years, initially with a platelet count of $2,000 \times 10^9$/L and abrupt transitory episodes of blurred vision, well controlled with hydroxyurea and aspirin. Because of her desire to become pregnant, hydroxyurea was discontinued. She was started on a therapeutic trial with IFN-α-2a and, after 2 months, a dose of 3 MU/sc every other day was found necessary to maintain the platelet count below 300×10^9/L. Thereafter, IFN was discontinued and the patient was placed on 200 mg qod of aspirin. Six months later, she became pregnant, and aspirin was withheld. After 2 months of pregnancy, the platelet count was $1,550 \times 10^9$/L and, once informed consent was obtained, IFN-α-2a was started at the dose previously tested of 3 MU/qod. During pregnancy the dose of IFN-α necessary to keep the platelet count below 500×10^9/L was 4,5 MU/day sc, until the delivery. Repeated ultrasound scans showed

a normal fetal development. A healthy male baby weighing 2,770 g was delivered vaginally at term without obstetric complications. The child has continued a normal development.

IFN-α has been used at diverse range of dosage for disease control during pregnancy in women with several myeloproliferative disorders and hairy cell leukemia without teratogenic or abortive effects reported [3,5].

Our experience suggests that young women of childbearing age with ET who are willing to become pregnant might undergo an IFN-α trial ahead of time to confirm their response to the drug and to find a temptative dose necessary to initially control the disease. IFN-α can then be administered during a subsequent pregnancy, adjusting the dosage to maintain an appropriate platelet count until delivery.

We did not observe any harmful IFN-α effect in the fetus, but the indications and safe use of IFN in the management of pregnant ET patients await further cumulative experience.

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JOSE L. DÍEZ-MARTÍN
M. HELENA BAÑAS
MANUEL N. FERNÁNDEZ
Servicio de Hematología, Clínica Puerta de Hierro, Universidad Autónoma, Madrid, Spain

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Acquired Factor V Inhibitor in a Patient With Acquired Human Immunodeficiency Syndrome

To the Editor: Autoimmune syndromes have been described in patients with human immunodeficiency virus (HIV) infection. Examples include autoimmune thrombocytopenic purpura (AIT) and antineuronal antibody-mediated neuropathies [1]. Acquired inhibitors have been reported with

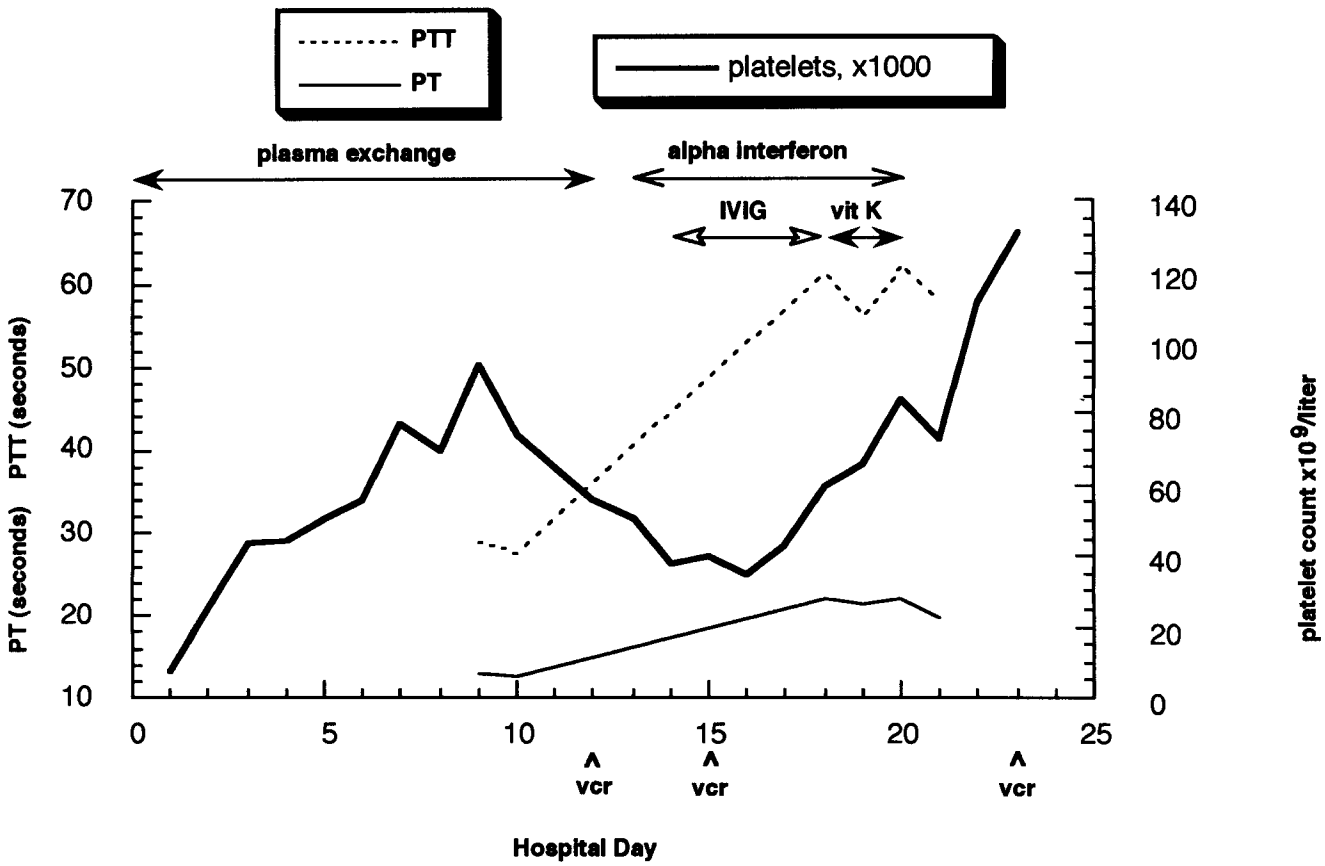

Fig. 1. Coagulation indices and treatment versus hospital day. Prothrombin time (PT), partial thromboplastin time (PTT), and platelets as a function of hospital stay. Plasma exchange was 14 units of FFP daily for days 1–6 and 12 units daily for days 7–12. IVIG dose was 24,800 mg every 24 hours days 14–18. Interferon-α dose was 3 million units sc day 13, 6 million units sc day 14, and 9 million units sc days 15–20. Vincristine (vcr) dose was 1 mg IV on days 12, 15, and 23. Vitamin K (vit K) dose was 10 mg IM days 18–20.